POLICY AND PROCEDURE

DEPARTMENT: Claims	**DOCUMENT NAME**: Encounter Data
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APPROVED DATE: 7/15/15	**RETIRED:**
EFFECTIVE DATE: 7/15	**REVIEWED/REVISED:** 7/15, 6/16, 6/17, 6/18, 6/19, 6/20, 2/22, 1/23
PRODUCT TYPE: Medicaid	**REFERENCE NUMBER:** LA.CLMS.05

SCOPE:

Louisiana Healthcare Connections (PLAN)

PURPOSE:

The purpose of this policy is to clearly define the PLAN guidelines for Claims Encounter Submissions to the state or its designee.

POLICY:

Encounter Data- Claims Encounter Data must be submitted in adherence to information as specified in Section ~~17~~ 2 of the current ~~2014~~ Contract effective 1/1/2023~~RFP~~ and in compliance with all applicable State and Federal laws, rules and regulations.

PROCEDURE:

1. **Encounter Data-** Identify all data elements as required by LDH for ~~E~~encounter ~~D~~data submission as stipulated in the *MCO System~~s~~ Companion Guide*; Accept submission of electronic adjustment and void transactions.

    a. The PLAN's ~~s~~System shall be able to transmit to and receive ~~encounter~~ electronic data from the ~~LDH~~ FI's system as required for the appropriate submission of ~~E~~encounter ~~D~~data.

    b. The PLAN shall create a unique Processor Control Number (PCN) ~~or~~ and unique Group number (if a group number is utilized) for ~~the~~ Louisiana Medicaid Program and ~~. The health plan~~ shall submit the PCN, ~~or~~ and group number (if a group number is utilized), and the Bank Identification Number with the ~~E~~encounter ~~Dclaims d~~ata submission.

2. **Encounter Data submissions**, the PLAN shall:

    a. Submit complete and accurate ~~E~~encounter ~~D~~data at least monthly for all dates of service during the term of this Contract to LDH or FI, as directed by LDH; and~~;~~

    b. ~~Due no later than the twenty-fifth (25th) calendar day of the month following the month in which they were processed (paid or denied), including encounters reflecting a zero dollar amount ($0.00) and encounters in which the PLAN has a capitation arrangement with a provider. If the PLAN fails to submit complete encounter data, as measured~~

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~~by a comparison of encounters to cash disbursements within a five (5) percent error threshold (at least ninety-five (95) percent complete), the plan may be penalized as outlined in Section 20 of the RFP~~Submit the Encounter Data in accordance with the Encounter reconciliation schedule published by LDH or its contracted review organization, including Encounters reflecting a zero dollar amount ($0.00) and Encounters in which the PLAN or its subcontractor has a capitation arrangement with a provider. If the PLAN or its subcontracted vendor(s), individually or in aggregate, fails to submit complete Encounter Data as measured by a comparison of Encounters to cash disbursements within a one percent (1%) error threshold (i.e., Encounters are at least ninety-nine percent [99%] but no greater than one hundred percent [100%] of cash disbursements), LDH may impose Monetary Penalties in accordance with Attachment G, *Table of Monetary Penalties*. LDH, at its sole discretion, may waive the penalty if Encounters processed by subcontracted vendors (e.g., pharmacy, non-emergency transportation, vision) fall below the completion threshold during the transition to a new vendor; however, this grace period shall not exceed ninety (90) Calendar Days for Encounters processed by either the exiting vendor or the new vendor.

3. ~~LDH's current FI accepts HIPAA compliant 837 encounters for Institutional Professional and Dental~~The PLAN shall submit HIPAA compliant 837 Encounters for Institutional, Professional and Dental, and the NCPDP D.0 format in a batch processing method for pharmacy Encounters. ~~LDH's FI accepts Pharmacy encounters using the NCPDP D.0 format in a batch processing method.~~ The PLAN shall be able to transmit this ~~e~~Encounter ~~d~~Data to the FI thirty ~~in this manner sixty~~ (3~~6~~0) Calendar D~~d~~ays after the ~~contract start date~~Operational Start Date. Inpatient Hospital Services (Institutional encounters indicating Facility Type Code of 11, 12, 18, 21 or 86) are ~~A~~adjudicated at the~~a~~ document -level. All other encounters are ~~A~~adjudicated at the line -level.

4. ~~PLAN's System shall submit encounter data to the~~As part of the Readiness Review, the PLAN's system shall be ready to submit Encounter Data to the FI according to specifications, including data elements and reporting requirements, in the *MCO System Companion Guide*~~in a provider to payer to payer COB format~~. The PLAN's system shall submit such Encounter Data within thirty (30) Calendar Days of the Operational Start Date. The PLAN ~~must~~ shall incur all costs associated with certifying HIPAA transactions readiness through a third party~~, EDIFECS~~ ,prior to submitting ~~e~~Encounter ~~d~~Data to the FI. ~~Data elements and reporting requirements are provided in the Systems Companion Guide.~~

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5. The PLAN shall provide the FI with complete and accurate Encounter Data for all levels of health care services provided, included all Claims paid, denied, adjusted or voided directly by the PLAN or indirectly through a subcontractor, regardless of whether the subcontractor's agreement has since termed~~All encounters shall be submitted electronically in the standard HIPAA 5010 transaction formats, specifically the ANSI X12N 837 provider to payer to payer COB Transaction formats (P – Professional, I – Institutional and NCPDP Pharmacy). Compliance with all applicable HIPAA, federal and state mandates, both current and future is required~~.

6. The PLAN shall have the capability to convert all information that enters its Claims system via hard copy paper Claims to electronic Encounter Data, for submission in the appropriate HIPAA compliant formats to LDH's FI.~~PLAN shall provide LDH with weekly encounter data on all prior authorization requests. The data shall be reported electronically to LDH in a mutually agreeable format as specified in the *Systems Companion Guide*. Contractor shall report prior authorization requests on all services which require prior authorization. The information reported shall contain but not be limited to:~~

~~a. Submitter ID~~

~~b. Plan Authorization Number~~

~~c. Authorization Type~~

~~d. Medicaid Recipient ID~~

~~e. Provider NPI~~

~~f. Provider Taxonomy~~

~~g. CPT / NDC/HICL/THERP CLASS~~

~~h. CPT Modifiers 1~~

~~i. CPT Modifiers 2~~

~~j. CPT Modifiers 3~~

~~k. CPT Modifiers 4~~

~~l. Referring Provider NPI~~

~~m. Plan Authorization Status~~

~~n. Authorization begin date~~

~~o. Authorization end date~~

~~p. Requested Units~~

~~q. Authorization Units~~

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r. Authorization amount ($)

s. Authorization received date

t. Authorization notice date

u. Authorization Denied Reason

v. Documentation Recevied Date

w. Tax Identification Number (TIN)

x.6. Auth Days and Hours Code

7. The PLAN shall provide the FI with complete and accurate encounter data for all levels of healthcare services provided, including all claims paid, denied or adjusted directly by the MCO or indirectly through a subcontractor.

8. The PLAN shall have the capability to convert, all information that enters its claims system via hard copy paper claims, to electronic encounter data, for submission in the appropriate HIPAA compliant formats to LDH's FI.

9.7. The PLAN shall ensure that all Eencounter Ddata from an PLAN sub-subcontractor is incorporated into files submitted by the PLAN to the FI. The PLAN shall not submit separate Encounter files from subcontractors.

10.8. The PLAN shall ensure the level of detail associated with Eencounters from providers with whom the PLAN has a capitation arrangement shall be equivalent to the level of detail associated with Eencounters for which the PLAN received and settled a fee-for-serviceFFS claim.

11.9. The PLAN shall utilize LDH provider billing manuals andthe *MCO System Companion Guide* to become familiar with the Celaims data elements that must shall be included in Eencounters. The PLAN shall retain all required data elements in Celaims history for the purpose of creating Eencounters that are compatible with LDH and theits FI's billing requirements.

12.10. The PLAN shall adhere to Ffederal and/or LDH payment rules in the definition and treatment of certain data elements, such as units of service that are a standard field in the Eencounter Ddata submissions and will be treated similarly by LDH across all PLANs.

13.11. The PLAN shall submit paid, denied, adjusted, and voided Celaims as Eencounters to the FI. LDH will shall establish the appropriate identifiers to

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indicate these ~~C~~encounters, ~~and information will be~~as provided in the *MCO Systems Companion Guide*.

~~14.~~12.   The PLAN shall ensure that ~~E~~encounter files contain settled ~~C~~claims, adjustments, denials or voids, including, but not limited to, adjustments necessitated by payment errors, processed during that payment cycle, as well as ~~E~~encounters processed during that payment cycle from providers with whom the PLAN has a capitation arrangement.

~~15.~~13.   The FI ~~E~~encounter process shall utilize a LDH-approved version of the ~~C~~claims processing system (edits and adjudication) to identify valid and invalid ~~E~~encounter records from a batch submission by the PLAN. Any submission which contains fatal errors that prevent processing, or that does not satisfy defined threshold error rates, shall be rejected and returned to the PLAN for correction and resubmission to the FI in the next payment cycle.

~~16.~~14.   ~~Any submission which contains fatal errors that prevent processing, or that does not satisfy defined threshold error rates, will be rejected and returned to the PLAN for correction and resubmission to the FI in the next payment cycle.~~ LDH has authorized ~~its~~their FI to edit the PLAN's ~~E~~encounters using a common set of edit criteria, that might cause denials, and the PLAN~~s~~ should resolve denied ~~E~~encounters when appropriate. Encounter denial codes shall be deemed "repairable" or "non-repairable". ~~An example of a repairable encounter is "provider invalid for date of service". An example of a non-repairable encounter is "exact duplicate"~~ The PLAN is required to be familiar with the FI edit codes and dispositions for the purpose of repairing Encounters denied by the FI. A list of Encounter edit codes is located in the *MCO System Companion Guide*.~~.~~

~~17. The PLAN is required to be familiar with the FI edit codes and dispositions for the purpose of repairing encounters denied by the FI. A list of encounter edit codes is located in *Systems Companion Guide*.~~

~~18.~~15.   In order to maintain integrity of processing, the PLAN shall address any issues that prevent processing of an ~~E~~encounter. ~~Acceptable standards~~The PLAN shall ~~be~~address ninety percent (90%) of reported repairable errors ~~are addressed~~ within thirty (30) calendar days and ~~ninety-nine~~one hundred percent (~~100~~~~99~~%) of reported repairable errors within sixty (60) ~~C~~calendar ~~D~~days or within a negotiated timeframe approved by LDH in writing. Failure to promptly research and address reported errors, including submission of and compliance with an acceptable ~~C~~corrective ~~A~~action ~~-~~~~P~~plan, may result in ~~M~~monetary ~~P~~penalties.

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19.16.   The PLAN CEO, CFO or their designee shall attest to the truthfulness, accuracy, and completeness of all Encounter Data submitted.

17. The PLAN shall~~must~~ make an adjustment to Encounter ~~claims~~s when the PLAN discovers the data is incorrect, no longer valid, or some element of the Claim not identified as part of the original claim needs to be changed except as noted otherwise. Incorrect provider numbers, incorrect Enrollee Medicaid ID numbers, or incorrect Claim types cannot be adjusted. Rather, the Encounter must be voided and resubmitted as an original. All other adjustments to an Encounter shall be done as an adjustment record.

18. Encounters submitted by the PLAN must contain the Claims data submitted to the PLAN by the provider without alterations, except for adjustments required for Claims processing as provided above. To the extent that the provider submits an adjusted Claim to the PLAN to correct missing or incomplete medical information, the PLAN must then submit the corrected Claim to the FI as an Encounter.

20.19.   If LDH or its ~~subcontractors~~ designee discovers errors or a conflict with a previously Adjudicated Encounter, ~~claim~~ the PLAN shall be required to adjust or void the Encounter ~~claim~~ within fourteen (14) Calendar Days of notification by LDH, or if circumstances exist that prevent the PLAN~~contractor~~ from meeting this time frame, by a specified date ~~shall be~~ approved by LDH in writing. The PLAN ~~must~~ shall obtain prior approval from LDH in writing for any submission to the ~~LDH's~~ Fiscal Intermediary for ~~that~~ numbers greater than one hundred thousand (100,000) ~~encounter claims~~Encounters.

REFERENCES:
PLAN ~~2014~~ 1/1/2023 Contract~~RFP~~ – Sections 2.18.15.1, 2.18.15.2, 2.18.15.3, 2.18.15.3.1, 2.18.15.3.2, 2.18.15.4, 2.18.15.5, 2.18.15.6, 2.18.15.7, 2.18.15.8, 2.18.15.9, 2.18.15.10, 2.18.15.11, 2.18.15.12, 2.18.15.13, 2.18.15.14, 2.18.15.15, 2.18.15.16, 2.18.15.17, 2.18.15.18, 2.18.15.19, 2.18.15.20~~17.1.1.5, 17.1.1.7, 17.8.1, 17.8.2, 17.8.3, 17.8.3.1, 17.8.3.2, 17.8.3.3, 17.8.4, 17.8.4.1, 17.8.5, 17.8.6, 17.8.7, 17.8.8, 17.8.9, 17.8.10, 17.8.11, 17.8.12, 17.8.13, 17.8.14, 17.8.15, 17.8.16, 17.8.17~~

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ATTACHMENTS:	[PDF] Attachment G, Table of Monetary Penalties

DEFINITIONS:

REVISION LOG	DATE
Encounter Data (1.): Deleted "DHH" per current RFP Added "and accurate" (2.) Combined & language updated per current RFP 17.8.3.3 (3. & 4.) Removed "DHH Posted" per current RFP (5.) Added "including all claims paid, denied or adjusted directly by the MCO or indirectly through a subcontractor" per current RFP (8.) Removed sentence re: separate files per current process (10.) Delete "the DHH posted" per current RFP (18.) Delete 17.8.18 in References – no longer in RFP Changed DHH to LDH	6/16
No revisions	6/17
No revisions	6/18
No revisions	6/19
Under the Encounter Data submissions section, changed Plan ID to Submitter ID and added Requested Units, Documentation ~~Recevied~~Received Date, Tax Identification Number (TIN), and Auth Days and Hours Code	6/20
Added sections regarding Encounter Data and associated timelines.	2/22
Encounter Data: changed "Section 17 of the current 2014 RFP" to "Section 2 of the current Contract effective 1/1/2023" Encounter Data (1.): changed "receive encounter data" to "receive electronic data"; added "(if a group number is utilized)"; changed "Louisiana Medicaid" to "the Louisiana Medicaid Program" Encounter Data submissions (2a.): added "for all dates of service during the term of this Contract to LDH or FI, as directed by LDH" Encounter Data submissions (2b.): Removed "Due no later than the twenty fifth (25th) calendar day of the month following the month in which they were processed (paid or denied)…"; Changed "ninety-five (95) percent complete" service level agreement to	1/23

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"encounters are at least ninety-nine percent [99%]"; added Attachment G, *Table of Monetary Penalties* and additional contract language.

(3.): changed "The Plan shall be able to transmit encounter data to the FI in … sixty (60) days after the contract start date" to "The Plan's system shall submit such Encounter Data within thirty (30) Calendar Days of the Operational Start Date."

(4.): added "The PLAN's system shall submit such Encounter Data within thirty (30) Calendar Days of the Operational Start Date"; deleted "EDIFECS"

(5.): added "The PLAN shall provide the FI with complete and accurate Encounter Data for all levels of health care services provided…"; deleted "All encounters shall be submitted electronically in the standard HIPAA 5010 transaction formats, specifically the ANSI X12N 837 provider to payer to payer COB transaction formats."

(6.): deleted "The information reported shall contain but not be limited to" and the individual list of data elements

(8.): changed "fee for service" to "FFS"

(9.): changed "utilize LDH provider billing manuals" to "utilize the MCO System Companion Guide"

(15.): Changed "ninety-nine percent (99%) of reported repairable errors within sixty (60) calendar days" to "one hundred percent (100%) of reported repairable errors within sixty (60) Calendar Days"; added "in writing"

(17.): added "Incorrect provider numbers, incorrect Enrollee Medicaid ID numbers, or incorrect Claim types cannot be adjusted. Rather, the Encounter must be voided and resubmitted as an original. All other adjustments to an Encounter shall be done as an adjustment record."

(18.): added "Encounters submitted by the PLAN must contain the Claims data submitted to the PLAN by the provider without alterations, except for adjustments required for Claims processing as provided above. To the extent that the provider submits an adjusted Claim to the PLAN to correct missing or incomplete medical information, the PLAN must then submit the corrected Claim to the FI as an Encounter."

Changed all instances of "*Systems Companion Guide*" to "*MCO System Companion Guide*"

(19.): changed "If LDH or its subcontractors discover" to "If LDH or its designee discovers"

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References: updated Section numbers per current Contract effective 1/1/2023, removed old Section numbers per 2014 RFP	

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Archer is considered equivalent to a physical signature.